3. HEALTH AND NUTRITION

Constitution of the Rights of the Child Articles

This section analyzes the right to health and access to health services, according to Article 24 of the Convention of the Rights of the Child. The article stipulates the right of all children, without discrimination to the ‘highest attainable standard of health’. This includes the right to safe water as one ‘essential for securing an adequate standard of living, particularly since it is one of the most fundamental conditions of survival’.

3.1 Key Data

What are the key issues making children vulnerable: situation and trends?

- Infant and under-five mortality rates have been substantially reduced. However, infant mortality rate (11.7 per thousand live-births) is much higher than the EU-27 average (4.3 per thousand live-births).
- Infant and under-five mortality rates are disproportionately higher among children from rural areas, boys, children from households within the lowest quintile, Roma children and children from the South region.
- Maternal mortality is still high and very far from the European average.
- The proportion of children under two years immunized against measles is very high. The proportion has, however, decreased, making not likely achievement of MDG target.

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Share of underweight children aged 0-5 years has considerably decreased.

Morbidity through anemia remains a major problem, with a constant increase between 2001 and 2010.

Mental disorders rate for children has increased between 2005 and 2010.

HIV/AIDS rate for the 15-24-year age group is on an upward trend in 2009-2010.

There is a shift in transmission routes of HIV/AIDS from injecting drug behavior to sexual intercourse.

Incidence of HIV/AIDS is much higher in the left bank of the Nistru than on the right bank.

Adolescents (15-19 years) have a considerably lower level of knowledge about STIs than do the 20-24 age group. In addition, only about one third of rural youth have correct knowledge of HIV transmission.

Stigma and discrimination against people living with HIV (PLWH) are widespread both among population and professionals from health and education sectors.

There is an increase in the alcohol use and a rather constant proportion of present smokers among teenagers 15-19 years old.

The prevalence rate of injecting drugs among youth is higher in Moldova than in the EU member states.

Suicide rate for teenagers (15-19 years) places the Republic of Moldova on an average position within the region.

Children’s access to safe water sources, sanitation and hygiene conditions is much lower in rural schools than in urban ones.

Family doctors to inhabitants ratio has undergone a decrease.

Lack of medical insurance for about 20% of the population, poor knowledge of parents and adolescents on health issues, underdeveloped transport infrastructure, out-of-pocket money, discriminatory attitudes of health personnel and adults represent factors that hinder access to health services.
3.2 Child Health and Survival

3.2.1 Infant and child mortality

The Republic of Moldova has substantially reduced the infant and under-five mortality rates reaching 11.7 per thousand live-births in 2010 for infant, respectively 13.6 per thousand live-births for under-five. The Millennium Development Goals (MDG)\textsuperscript{44} for 2010 and 2015 has been already achieved for both indicators.\textsuperscript{45} This is mainly the result of various health programs implemented by the Government with the support of country development partners,\textsuperscript{46} such as the regionalization of perinatal medical assistance, establishing a national system of monitoring and observation of perinatal medical assistance or implementing \textit{in vitro} transportation. However, constant efforts in reducing child mortality further are still needed since the infant mortality rate in Moldova is more than two times higher than the EU-27 average of 4.3 per thousand live-births.\textsuperscript{47}

\textbf{Figure 3.} Infant and under-five mortality rates

![Infant and under-five mortality rates graph](image.png)

The infant mortality decreased also in Transnistria, according to the data provided by the region authorities, reaching in 2009 an infant mortality rate of 8 per thousand and an under-five mortality rate of 10 per thousand.\textsuperscript{48}

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\textsuperscript{44} These targets are set to 16.3 per 1,000 live births in 2010 and 13.3 in 2015 for the infant mortality and 18.6 per 1,000 live births in 2010, and 15.3 in 2015 for the under-five mortality rate.

\textsuperscript{45} This is also the result of two facts, (1) the revision in 2007 of the MDG goals based on a wrong presupposition (that statistics provided by medical institutions within the monitoring mechanism would under-estimate infant mortality) and (2) the adoption in 2008 of the definition of live-birth recommended by WHO, according which for measuring infant mortality rate are taken into consideration death after 22 weeks of pregnancy and a child weight of 500 g (instead of 28 weeks of gestation and 1000 g respectively). The adoption of the new methodology resulted in a sharp increase of the infant mortality rate in 2008, which however declined in 2009-2010.

\textsuperscript{46} Government of Japan, Switzerland, European Bank for Reconstruction and Development, UNICEF, Swiss Agency for Development and Cooperation, and World Bank have provided financial assistance to reduce child mortality.

\textsuperscript{47} Eurostat database, date of access: August 8, 2011.

\textsuperscript{48} UNICEF, \textit{Ensuring survival, care and protection of young children in Moldova: extension of the IMCI Initiative in Transnistria}, 2010: 6. In Transnistria old definition of live birth is used (starting with 1,000 gr).
The most important causes for infant mortality are related to maternal and infant health during pregnancy. Among infant and under-five deaths, perinatal causes were the most common in 2010 (39.9%), followed by congenital malformations (29.4%), respiratory illnesses (13.4%), traumatic injuries and poisonings (6.5%) and infectious diseases (3.4%). Consequently, although the national system of pre-natal care has been developed, it still needs improvements particularly regarding the surveillance during pregnancy of women who migrated for work abroad.

Still almost 20% of deaths of children under-five happen at home, the majority of cases from preventable causes of deaths such as injuries, poisoning, infectious and respiratory diseases. Most of these cases occur among vulnerable children. For example, a WHO study shows that in Eastern Europe the infant respiratory deaths are linked to the poorer economic and environmental situations, which account for a greater proportion of severe acute respiratory infections.

Infant and under-five mortality rates are disproportionately higher among:

- children from rural areas, for both female and male infants;
- boys, as fewer girls were born every year than boys;
- children from households within the lowest quintile; and
- Roma children.

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52 The urban-rural gap has widened since 2000 for infant mortality as well as for under-five mortality.


There is significant variation in the incidence of child mortality across regions. Infant mortality rates are higher in the South region of the country compared to Chisinau region where children have the highest survival chances in the first five years of life. The districts with the highest rates of infant mortality in 2009 were Basarabeasca, Glodeni, Calarasi, Cahul, Leova, Hancesti, Criuleni and Floresti. \(^{55}\)

### 3.2.2 Maternal Health

Similar to infant mortality, the indicator on maternal mortality rate is used for assessing the country general development, including the efficiency of health systems. Yet, it has to be cautiously interpreted as the indicator (ratio to 100,000 live-births) is highly sensitive to any increase in absolute number of cases. Thus, the 18 cases registered in Moldova in 2010 increased the maternal mortality rate to 44.5 cases per 100,000 babies born alive. \(^{56}\) However, Moldova registered progress in the period of 2001-2007 and, even though the value of the indicator is very far from the target set for 2010 (15.5 per 100,000 live-births), the latest MDG report positively evaluates country’s probability of reaching the MDG 2015 target of 13.3. In order to correct errors in computation of this indicator due to the small number of live births, Moldova follows now the World Health Organization recommendation and has reported in the *Annual Health Report* from 2010 a three-year-average (2008-2010) of 33.4 cases per 100,000 live-births. Even with the new computation method, the value of the indicator on

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\(^{55}\) National Centre for Health Management, *SPD2 2009-2013*.

\(^{56}\) Compared to 38.4 cases in 2008, corresponding to 15 cases, or to 17.2 per 100,000 live-births in 2009, corresponding to 7 cases.
maternal mortality is still very far from the European average of 4.28 cases per 100,000 babies born alive.\(^{57}\)

Structure of maternal mortality in 2008 indicates hemorrhages as main cause, followed by late gestosis, septic states, thromboembolism, hepatic cirrhosis and anesthetic complication. Further analysis attributes 47% of maternal deaths to social causes, such as: (i) women working abroad; (ii) migratory life-style which includes women mostly from rural areas, working in seasonal activities, in hard conditions, considered as a risk for health; and (iii) patients not seeking medical help – attributed to the low level of information and knowledge. For the year of 2008, 58% of deceased women were from the rural area.\(^{58}\)

In what concerns the other MDG maternal health related target, Moldova has already reached the target set for 2010, as 99% of births were assisted by medical staff. Still, rural and income disparities in access to health services cannot be ignored. Anemia accounts for other complications during pregnancy and childbirth, and the situation worsened in 2009, as the number of anemic pregnant women increased.\(^{59}\)

Situation of teenage mothers is a key factor for maternal health. The reported average age at first birth, although it has declining in the past 10 years, is the lowest in Moldova (22.5) across SEE, CEE and CIS regions. Correspondingly, the birth rate in the age group 15-19 years is high (28.7 per 1,000 live-births in 2006).\(^{60}\)

In 2010, there were 3790 live-births with mothers under 20 years which represented 9.4% of total live-births.\(^{61}\) 80% of them are located in the rural area. Adolescent fertility rate is much higher in Moldova than in the European Union.\(^{62}\) Teenage mothers face a higher risk of dying from maternal causes compared to women aged 20s or 30s. Adolescents under 16 have a risk of maternal death four times higher than do women aged 20 plus. Their babies have a higher risk of death also. Moreover, they face various other risks, including school dropout, child abandonment, poverty, unemployment or human trafficking.\(^{63}\)


\(^{59}\) Ibid., 2010: 68.


\(^{62}\) Adolescent fertility rate is the number of births per 1,000 women ages 15-19. For 2009, the rate for Moldova is 31.9, compared to the European Union where it is 13.5. Source: United Nations Population Division, World Population Prospects in World Bank, *World Development Indicators*, http://data.worldbank.org/indicator, October 16, 2011

Roma women as well as women from low-income households address the prophylactic health services to a much less extent than do women from better-off households. These two categories tend to contact a gynecologist only during pregnancy, when they are covered by medical insurance, or for a specific health problem. The main barriers for them to access the system refer to the transportation related costs, out of pocket money or other hidden fees.64

### 3.2.3 Immunization

The proportion of children under two years immunized against measles is very high in the Republic of Moldova, according to the WHO among the highest in the world.65 The proportion has, however, slightly declined from above 96% in the period 2005-2007 to 94.4% in 2008, which puts in danger the reach of the MDG target for 2010 (no lower than 96%). The accomplishment of this MDG greatly depends on the implementation of National Immunization Programs and actions for increasing awareness of the positive effects of child vaccination against measles.

The situation is much worse in the Transnistrian region where immunization coverage is only 71.3%.66

**Figure 5.** Coverage rate with immunization

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65 Government of the Republic of Moldova, Moldova’s Report on IADGs Implementation. Annual Ministerial of the ECOSOC, 2010: 9. Based on the Nation Master world-wide database including data gathered from sources such as the UN, OECD, and Central Intelligence Agency.
66 UNICEF Moldova, September 2011.
The immunizations for other diseases follow a similar trend to that of the measles, an upward trend up to 2007, followed by a decline in the period of 2007-2009. Resistance of parents to immunization is mentioned in several reports as an obstacle to an increased coverage rate.\textsuperscript{67}

Although the majority of caregivers have a yellow immunization card, in some territories like Cahul, Cădăr Lunga and Bender, these cards have not been systematically provided.

Equity analysis shows a negative correlation between mother’s level of education and the rate of immunization. Children from urban area and those from North and Chisinau municipality have a lower rate of immunization compared to the children from South and Centre part of the country. Explanations relate to the stronger ties in the rural areas, enabling an easier mechanism of convincing the population. On the other side, better information level of women with higher levels of education regarding the secondary effects of immunization leads to a lower rate of acceptance.\textsuperscript{68}

Another gap relates to the Roma children, less covered by immunization program. Among children under 14 years old, 11% of Roma children are not vaccinated in comparison with 3% of non-Roma. Reasons mentioned by Roma respondents include lack of insurance policy and of information ‘did not know it was necessary to be vaccinated’.\textsuperscript{69}

\textbf{3.2.4 Nutrition}

Good nutrition is the foundation for survival, health and development. At the macro-level, a well-nourished population has higher productivity, lower health care costs and greater economic output. At the micro-level, ‘well-nourished women face fewer risks during pregnancy and childbirth, and their children set off on a firmer developmental path, both physically and mentally. Well-nourished children perform better in school, grow into healthier adults and are able to give their own children a better start in life.’\textsuperscript{70} Opposite, undernourished children have lower resistance to infection and, during their life, may be locked into ‘the vicious cycle of recurring sickness and faltering growth, often with irreversible damage to their cognitive and social development’. (ibid.)


\textsuperscript{68} Center for Health Policies and Analysis in Health, UNICEF, \textit{Maternal and Child Health Equity Analysis}, 2009: 32. The study took into consideration the case of immunization with DTP3 and hepatitis B3.


In the Republic of Moldova, the rates of malnutrition\textsuperscript{71} have considerably decreased for children in the first year of life as well as for children under five years old.\textsuperscript{72} After 2000, the share of underweight children aged 0-5 years has had a sharply declining trend, reaching in 10.6\% in 2009, almost a half of the 2000 value (figure 6). The positive trend in malnutrition is correlated with the good evolutions in the rate of exclusive breastfeeding in the first six months of life, which increased from 73.6\% in 2000 to 87.7\% in 2010.

The second MDG report acknowledges the positive changes in the area of nutrition, by improvements in the share of underweight children aged 0-5 years and infant malnutrition. Nevertheless, the Republic of Moldova is still above the EU average for this indicator.\textsuperscript{73}

An equity analysis indicates that underweight children are concentrated in poor households.\textsuperscript{74} In the same time, the prevalence of food deprivation among general population is correlated with household income, households of three or four members, and urban population.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure6.png}
\caption{Share of underweight children aged 0-5 years (\%)}
\end{figure}

\textsuperscript{71} Malnutrition data, only as a disease, is collected based on administrative data. Data regarding stunting and underweight is collected only through household based surveys (Multiple Indicator Cluster Survey -MICS and Demographic Health Survey -DHS).
\textsuperscript{74} Center for Health Policies and Analysis in Health, UNICEF, Maternal and Child Health Equity Analysis, 2009: 27 and 35. Data for 2005 regarding underweight children and data for 2006 regarding food deprivation, which is measured as the share of population for which the caloric intake is less than the necessary minimum of 2500 kcal.
In rural areas, the incidence of food deprivation is lower, as agriculture represents the main source of income for most households. Nevertheless, the quality of nutrition is rather poor. Of the children aged 0-7 years, one in every six from rural areas and one in every five from low-income households have three meals per day or less. Moreover, children from rural areas as well as children from low-income households have a rather monotonous diet consisting in fruits and vegetables, dairy and meat products considerable less compared to the children from urban areas or those from better-off households. Thus, the most important predictors for the quality of nutrition are the socio-economic status and residence area, rural areas being at disadvantage compared to urban areas.

However, the quality of nutrition appears as a widespread issue within the country since less than 33% of children 0-7 years eats meat or fish products daily, only 50% consume dairy and 62% of them benefit on fruits and vegetable every day.

Given the coping strategies of households in response to the economic crisis, in 2010-2011, the quality of nutrition is likely to being decreased while food deprivation to being increased. During the crisis, consumption expenditures of households decreased significantly. The highest fall in spending was reported in food expenditures (-13% at the national level), both in low-, mid- and high-income households, in households with and without children, in complete as well as incomplete families. As result, people shifted from high and mid-priced staples to cheaper food products. The rural areas were less affected as in kind food consumption is the main coping strategy of rural households. In cities, and particularly in small towns, the drop in food expenditures was much more important. Consumption of food in lower quantities and of lower quality could lead to a deterioration of the health status of population, particularly of children. There is still no empirical evidence that the health situation is worsening, but the phenomenon should be closely monitored, especially if the crisis continues.

Morbidity through anemia remains a major problem, with a constant increase between 2001 and 2010, to 116.2 per 1,000 children under five years old. In the first year of life, morbidity through anemia is even

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higher, 237 cases of every thousand infants (in 2010), and has followed the same upward trend in the last ten years.\textsuperscript{78} Nonetheless, this increase is attributed mainly to a better screening, as part of the Integrated Management of Childhood Illnesses Initiative (IMCI Strategy), supported by UNICEF Moldova.\textsuperscript{79} So, the problem is not necessarily bigger, but it becomes increasingly visible.

**Table 1. Anemia in children under five years of age (per 1,000 children of this age)**

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia in children under 5 years</td>
<td>74.1</td>
<td>69.3</td>
<td>81.7</td>
<td>86.9</td>
<td>91.2</td>
<td>102.2</td>
<td>103</td>
<td>106.6</td>
<td>107.5</td>
<td>106.3</td>
<td>116.2</td>
</tr>
</tbody>
</table>

*Change from 2010 to 2000: 1.57*


The situation is different in Transnistria.\textsuperscript{80} There is a significant decrease in anemia cases among children under five from 1,723 in 2007 to 1,208 in 2009.\textsuperscript{81}

Anemia of children under one year is closely linked to maternal anemia. High rates of anemia among children reflect the higher likelihood of these children to live in poor socio-economic conditions, where women are more susceptible to poor diet and infection and more likely to undertake physically demanding work during pregnancy or breastfeeding. Correspondingly, the incidence of anemia among children significantly varies with residence, region, mother’s level of education and income level, besides the child’s age. Children from rural areas, particularly in the Center region, with poorly educated mothers and from low-income households have a higher risk of anemia.\textsuperscript{82}

A National Program addresses this problem through ensuring a supplement of iron and folic acid for pregnant women as part of the basic package of

\textsuperscript{78} National Bureau of Statistics. However, for the children in the first year of life, anemia represents only the second cause of morbidity. For example, in 2010, the main cause of morbidity was respiratory diseases (725 cases per 1,000 children), followed by anemia (237 cases per 1,000 children), perinatal pathologies (151 cases per 1,000 children) and diseases of the nervous system (104 cases per 1,000 children).


\textsuperscript{80} UNICEF, Ensuring survival, care and protection of young children in Moldova: extension of the IMCI Initiative in Transnistria, 2010: 6.

\textsuperscript{81} Morbidity through anemia reported by authorities is higher than in Moldova, but it has decreased as result of improvements in detection and treatment.

prevention services and treatment of anemia. Nevertheless, the persistent high levels of morbidity through anemia among children call for a more efficient implementation plan.

3.2.5 Children with disabilities

**Figure 7.** Main causes of children invalidity (per 1,000 children under 18 years old)

The number of children invalidity cases increased from 12,859 in 2005 to 15,321 in 2010.83

Main causes of children invalidity are represented by congenital malformations and chromosomal anomalies (increased from 4.1 in 2005 to 5.5 per 1,000 children under 18 years old, in 2010), mental and behavior disorders and diseases of nervous system.

Article 23 of the Convention of the Rights of the Child mentions, among others, the right of the disabled child to enjoy the effective access to education, health care services, rehabilitation services, preparation for employment, and recreation opportunities. Non-discrimination as intrinsic principle of the Convention should guide policy-makers in ensuring that all children, including those with disabilities, enjoy full access to public services.

Access to the health care services of children with disabilities is problematic, even in the first stages of child development. Early intervention services, community based services as well as inclusive education have been developed only in three districts of the country (Chisinau, Criuleni and

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Balti), whereas in seven districts none of those are available. In most districts, only the community based services have been put in place.

The National Centre of Mother and Child from Chisinau provides complex services during prenatal and postnatal period for approximately 1,000 children from the whole country. However, its location in the capital city prevents access for a part of the parents, including visits for follow-up services.\textsuperscript{84}

Aside that relevant services are underdeveloped the existent ones are poorly endowed with equipments. Accordingly, many doctors involved in early intervention detection, therapies and prevention, use outdated methodologies. Thus, upgrading professional capacities of those doctors is critical for improving the system performances. This is especially true for doctors working in remote districts.

Furthermore, the facilities for people with disabilities are deficient both in public institutions and in the public transportation system. Although various strategic documents have been formulated, the provisioned activities are still at a general level and there are no clear mechanisms of implementation, control and evaluation.\textsuperscript{85}

Another major problem is the late diagnosis for many children with a disability. Under the conditions of a weak system, the late diagnosis occurs particularly when parents do not know to identify the signs or symptoms related to a disability, even more so when the family is poor and/or lives in a remote area. The phenomenon is even more accentuated in the case of disabilities with no visible signs, such as those caused by mental and behavior disorders. Generally, the diagnosis takes place when the child enters in the first grade of school, a phase from which the child continues with the mainstream education or is referred to a special school.

\textsuperscript{84} UNICEF, \textit{Assessment and Recommendation on Child Disability Prevention and Care System in Moldova}, 2009.

\textsuperscript{85} Ombudsman Institution, \textit{Thematic Report ‘People with special needs’ access to social infrastructure: reality and necessity’}, 2010.
Figure 8. Number of children with disabilities (0-18 years) and availability of relevant services by district

Source: UNICEF, Assessment and Recommendation on Child Disability Prevention and Care System in Moldova (2009), p. 52
Moldova has a high prevalence of mental disorders in the general population as compared to new EU countries and CIS region. Previous reports draw attention on the difference in the classification system as being the most probable explanation for the high prevalence of mental disorders in Moldova. In addition, they point out that in Moldova the cases of mental retardation are over-estimated while psychiatric disorders are misdiagnosed in the case of some psychological and social issues related to conflict situation.

The incidence of mental and behavior disorders among children aged 0-18 years is higher compared with the adults. More worrying is that the mental disorders rate for children has increased between 2005 and 2010 from about 524 to 637 cases per 100,000 children respectively. Main factors contributing to children mental disorders refer to family conflicts, family separation and parents’ migration, as well as conflicts at school.

### 3.3 Adolescent Health and Development

#### 3.3.1 HIV/AIDS

Incidence of HIV/AIDS in the general population has decreased since 2008 reaching 17.12 cases for every 100,000 inhabitants in 2010. The HIV/AIDS rate for the 15-24-year age group has followed a different trend. After a sharp drop in 2008, it resumed the upward trend in 2009-2010, coming back at the high 2007 level, about 21 cases per 100,000 inhabitants. Thus, in 2010, the stable pattern of considerable higher rates of HIV/AIDS for the young (15-24 years) was restored.

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87 Ibid.
The MDG targets set for the general population, as well as for the 15-24-year age group, were revised downwards in 2007, as a result of a continuous deterioration on these indicators. However, given the existing trends, the targets set at 8 and 10 per 100,000 inhabitants (for 2010 and 2015 respectively) are very improbable to be achieved, even after these revisions.

**Figure 9.** Trends in HIV/AIDS incidence in Moldova by age groups, 2000-2010 (100,000 inhabitants)

**Figure 10.** Trends in HIV/AIDS incidence in Moldova by region, 2001-2009 (100,000 inhabitants)
Various studies and reports regarding HIV epidemic set out the specific characteristics and trends for the Republic of Moldova:

(I) There is a shift in transmission routes of HIV/AIDS from injecting drug behavior to sexual intercourse. In 2010, 86.8% of the newly registered cases were attributed to sexual transmission.90

(II) Four groups of population (irrespective age) have a disproportionally high risk of HIV/AIDS infection, namely injecting drug users, commercial sex workers, men who have sex with men and inmates.91

(III) There are significant differences between the right and the left bank of the Nistru. The incidence in the Transnistrian region is of 42.25 cases per 100,000 inhabitants, which is more than three times larger than the rate of 12.42 cases of the right bank of Nistru.92 On both banks, the young of 15-24 years account for similar proportions of all reported cases, 21.6% in the right bank and 23.8% in the left bank of Nistru.93

(IV) The ratio between male and female changed in 2004, most probably affected by the introduction of mandatory testing for women during pregnancy. The Second MDG report draws attention on the problem of high prevalence of gender violence, which leads to a decreased

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93 UNAIDS, http://aids.md
negotiation power of women in what concerns condom-use for high-risk sexual relationships. Adding to this the limited condom availability, especially in rural areas, women vulnerability to HIV is quite high.94

(V) Mother-to-child HIV transmission rate greatly decreased from 10% in 2004 to 1.7% in 2008 and afterwards it has remained below 2%. Nevertheless, considering that the prevalence of HIV among pregnant women has continued to rise, the services system for prevention of HIV transmission from mother to child requires improved efficiency. A recent assessment of this system identifies the following areas for development: ‘oversight mechanism, management and coordination, sustainability and continuum of service provision, access and quality of services’.95

There is significant variation in the youth’s knowledge about safer sex behavior across areas of residence as well as age groups.96 In 2008, only about one third of rural youth have correct knowledge of HIV transmission. Adolescents (15-19 years) have a considerably lower level of knowledge about STIs than do the 20-24 age group. Between 2006 and 2008, the level of knowledge has increased (with 15% about HIV and with 12% about condoms),97 but continues to be low among adolescents.

**Figure 12.** Indicators of knowledge, attitudes and practices in youth aged 15-24 years (%)

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96 Scutelniciuc et al. (2008), (2006).

97 HIV knowledge is an index composed based on correct answer to four questions: (i) ‘Can HIV infection risk be reduced through a correct use of condom at every sexual intercourse?’; (ii) ‘Is HIV infection risk reduced if having one faithful and non-infected sexual partner?’; (iii) ‘Can HIV be transmitted by having lunch using the same cover with an infected person?’; and (iv) ‘Can a person apparently healthy be HIV infected?’ Similarly, knowledge about condoms is an index computed of correct answers to three questions: ‘Can HIV infection risk be reduced through a correct condom use at every sexual intercourse?’, ‘Can STI infection risk be reduced through a correct condom use at every sexual intercourse?’ and ‘Can an unwanted pregnancy be prevented through a correct condom use at every sexual intercourse?’.
Tolerant attitudes towards people living with HIV (PLWH) have remained alarmingly low among young, despite the significant efforts to reduce stigma towards PLWH.

The sexual preventive practices of young did not improve between 2006 and 2008. Only 5-6% of young (15-24 years) took voluntarily HIV testing and know the result, of which very few from rural areas. The condom use at last sex with an occasional partner did slightly decrease from 75% to 71%. More, less than half of the young use condoms consistently with commercial sex workers. An increasing share (from about 10% to 16%) had multiple sexual partners during the last 12 months.

Various prevention programs have been implemented and rapidly extended. Nonetheless, they failed to keep up with the pace of HIV evolution as some of them were only partially implemented.98 They are unequal in geographic and sub-population coverage. There is a clear insufficiency of services addressing the adolescents, particularly of those of social inclusion, accompanied by a low access to condoms and harm reduction programs. In addition, prevention programs focus on raising awareness rather than behavior change.

People living with HIV (PLWH) face serious social inclusion problems. A survey report from 2008 99 shows that less than half of the respondents (44.3%) hold a health insurance, only 38% of them are employed, and approximately half of PLWH parents with children have incomplete families.101 Therefore, most of them have a low income and live in poor conditions.

Stigma and discrimination against PLWH are widespread both among population and professionals from health and education sectors. Half of respondents declared they felt discriminated because of their HIV status. Respondents infected through injecting drugs reported more frequently discrimination episodes than those infected probably through sexual intercourse. In addition, the qualitative study revealed that many PLWH parents face resistance when trying to access educational institutions. In this way, the discrimination against parents may affect the child’s chances to education. As a survival strategy, many PLWH parents with children

100 Data refer only to the right bank of the Nistru.
101 Divorced, separated, widowed and single.
going to school or kindergarten avoid informing the institution that the child belongs to a family affected by HIV.

Confidentiality regarding PLWH is also problematic, as many medical professionals do not observe this rule. Almost half of respondents declared that people knew about their HIV positive status from someone else, including physicians and other people whom they previously told.

3.3.2 Substance use

A study\textsuperscript{102} on youth’s knowledge, attitudes and practices carried out in 2006 and 2008 shows an increase in the alcohol use and a rather constant proportion of present smokers, among teenagers 15-19 years old. In terms of gender disparities, significantly more boys than girls adopt these risk behaviors, drinking alcohol and/or smoking.

**Figure 13.** Substance use among adolescents (15-19 years) in Moldova, 2006 and 2008 (%)  
![Substance use among adolescents](image)

The alcohol use is spreading both among boys and girls. High share of adolescents who drink alcohol is alarming, even more so considering that the alcohol consumption is considered a ‘problem’ by fewer young than the smoking. Thus, the peer group environment is rather restrictive regarding smoking but it is tolerant and provides an anticipatory socialization into drinking alcohol.\textsuperscript{103} This is a major source of concern knowing the strong links between high-risk drinking, violence, unsafe sexual behaviors, traffic and other accidents, permanent disabilities and death.

\textsuperscript{102} Scutelniciuc et al. (2008).

A survey on school-going adolescents showed that 83% of adolescents declared that would like to quit smoking.\textsuperscript{104} Although the Republic of Moldova has approved the Law on Framework Convention on Tobacco Control in 2007, the laws against underage smoking are not enforced: shops continue to sell to teenagers. An effective way to tackle this issue would be a tax increase on cigarettes, as Moldova still has the lowest price of cigarettes in Europe.\textsuperscript{105}

Moldova is a source-country for cannabis, which alongside poppy is a cultivated drug. Cannabis represents the most commonly used drug in the general population of the country.\textsuperscript{106}

The first European School Survey for Alcohol and Other Drugs (ESPAD), carried out in 2008, indicated a life-time prevalence\textsuperscript{107} of cannabis of 4.8% among school children born in 1992, with a much higher prevalence for boys than for girls.

At the level of the youth aged 15-24 years old, both the life-time and the last year prevalence of cannabis are much lower in Moldova than the EU-27.\textsuperscript{108} Disaggregated statistics for 15-19 age group indicate gender and residence area disparities. Both life-time and last year prevalence is higher for males than for females and higher in urban versus rural areas.\textsuperscript{109}

The overall number of drug users is not known, as there are no reliable estimations of the number of injecting drug users (IDUs) in the Republic of Moldova. However, recent studies set out several findings useful for guiding policy interventions:

- The prevalence rate of injecting drugs (assimilated to opioid drug use) among youth is higher in Moldova than in the EU member states.\textsuperscript{110}


\textsuperscript{107} Life-time prevalence is any use of a specific drug during one’s lifetime, regardless of other characteristics (quantity, frequency).


The average length of time on injecting drugs has increased. Opium extract is the most frequently injected drug, followed by ephedrine, ‘vint’, tranquilizers and heroin.111

Injecting drug users have high risks of experiencing health problems, such as blood-borne infections (HIV/AIDS, hepatitis) or drug overdose.112

Low proportions of adolescents injecting drugs benefit from services of Harm Reduction Programmes during a year (less than 28% in the case of IDUs aged 15-17 years). Most of them benefited of distribution of condoms, needle exchange, distribution of disinfectants, and information materials.113

The coverage of HIV prevention interventions is very low for children 12-14 years as well as for adolescents 15-17 years (about 11%).114

Design and implementation of dedicated policies and practices should take into account the reported high rates of indirect sharing as well as sexual risky behavior, especially among young injecting drug users.115 Respondents from Tiraspol are more likely to practice indirect sharing compared to Balti and Chisinau respondents.

The Annual Report on Drug Situation in the Republic of Moldova from 2008 concludes that no progress has been made in improving the monitoring of drug-related deaths on the basis of an internationally accepted definition, as only a small number of cases have been reported by the Centre of Forensic Medicine.116

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113 Ministry of Health, Assessment of Risk of HIV Infection among Most at Risk Adolescents (MARA), 2009: 53. Data from 2008. An IDU was considered to be someone aged 12-24 years who has injected drugs at least once during the 12 months prior to the interview. The study covered the district centers and rural communities neighboring Chisinau, Balti and Tiraspol municipalities.
114 Although most IDUs know where they may take a HIV test, only 5.3% of 12-14-year-olds and 14.1% of 15-17 years old IDUs have ever taken such a test. Ministry of Health, Assessment of Risk of HIV Infection among Most at Risk Adolescents (MARA), 2009: 51-53. Data from 2008. An IDU was considered to be someone aged 12-24 years who has injected drugs at least once during the 12 months prior to the interview. The study covered the district centers and rural communities neighboring Chisinau, Balti and Tiraspol municipalities.
115 Indirect sharing of syringes in the last month accounts for 85.3% of respondents and decreases with age from 100% in the 12-14 year-olds, compared to 81% in 20-24 year-olds. The highest rate of multiple partners and non-steady partners in the last year was found in the 15-17 years age group, of which 65.3% have 4.2 sexual partners on average. Ministry of Health, Assessment of Risk of HIV Infection among Most at Risk Adolescents (MARA), 2009: 9 and 43. Data from 2008. An IDU was considered to be someone aged 12-24 years who has injected drugs at least once during the 12 months prior to the interview. The study covered the district centers and rural communities neighboring Chisinau, Balti and Tiraspol municipalities.
In conclusion, adolescent IDUs are at greater risk of HIV and Sexually Transmitted Infections compared with IDUs aged 18-24 years. Primary prevention of drug use is limited. Treatment options available to drug users are also limited, as the main service is detoxification both in public and private sectors. Detoxification is mainly provided, with no additional treatment modalities. Methadone substitution treatment covers insufficiently those in need. Rehabilitation services for IDUs are underdeveloped, especially for young people below 18 years old. The few existing services have a small number are of beneficiaries and are offered the National Center for Narcology and a few NGOs.

Moldova has an extended network of harm reduction services, but the range of provided services has decreased with the shrinkage of funding from the past years. Given that HIV transmission in IDUs is presently linked to indirect sharing and high-risk sexual behaviors, which both are specific to adolescents aged 15-17 years, this will likely translate in higher HIV/STI transmission rates in the future.  

### 3.3.2 Suicide

Moldova is a high suicide rate country, with more than 17 suicides per 100,000 people. At the population level, suicide rates are rather constant, with higher shares for men. In 2009, the suicide rate for youth aged 15-19 was 5.1 deaths per 100,000 relevant population.

Figure 14 shows that the suicide rate for teenagers (15-19 years) situates the Republic of Moldova on an rather low position within the region. Among teenagers, the rate of suicide is higher for males than for females.

119 Death rates due to suicide: 32.43 deaths per 100,000 inhabitants of respective age and sex, in 2009, for males compared to 5.13 deaths per 100,000 inhabitants of respective age and sex for females. National Bureau of Statistics, Statistical Yearbook of the Republic of Moldova 2010, 2010: 54.
120 UNICEF, TransMONEE 2011 Database.
However, statistics on suicide are not accurate. Different agencies provide divergent data. National suicide prevention services are very limited. The available community services are highly dependent on external donor support. As in the case of mental health disorders, suicide attempts are treated in psychiatric hospital or special institutions for children, whereas long-term interventions to help family and community reintegration are scarce.\textsuperscript{121}

### 3.4 Access to Water and Sanitation

The share of people with access to improved water sources has considerably increased in Moldova, from 38.5% of population in 2002 to 55% in 2009. However the large urban-rural disparities persist. Maintaining the investments rhythm from the last years, which requires a large funding from both State Budget and external donors, is critical for attaining the 2010 (of 59%) and 2015 MDG targets (65% of population). For this reason the second MDG report on Moldova evaluates as ‘(probably) unlikely’ the country’s chances to reach the targets related to access to improved sewerage and sanitation systems, despite the extensive project supported by the European Commission on water supply and sewage.\textsuperscript{122}


\textsuperscript{122} Project of 45 millions euro to improve access to water and sewage facilities in Moldova. UNICEF, Summary Report Study on the Quality of Water, Sanitation and Hygiene Practices in the schools of Moldova, 2010: 91.
There are significant regional disparities regarding the availability of drinking water, with the south part at disadvantage. Furthermore, in the next years, the country is expected to face a risk of water-scarcity.

Children’s access to safe water sources, sanitation and hygiene conditions was the focus of a study in the schools of Moldova. This study brings additional evidence on the urban-rural disparities:

- Approximately one third of schools from rural areas do not have a water supply system. The share of schools connected to water is lowest (less than 20%) in Soldanesti district.
- 80% of schools that do not comply to the sanitary protection zones for water sources are located in the rural area.
- Interruptions in water supply, which are associated with higher risk of microbial pollution of water, occur most often in the southern area.
- One in every six pupils in Moldova is at risk of acquiring acute diarrheal diseases due to polluted water. Also, one in every ten children uses WCs non-compliant with the sanitation norms, which increases the risk of acute diarrheal and parasite diseases.
- One in every four pupils is exposed to a major health risk due to water consumption at school. Risk factors are microbial, nitrate, fluoride and boron pollution of water for human consumption. The districts falling within the major health risk category are Soldanesti, Edinet, Donduseni, Ungheni, Soroca, Gagauzia (Ciadir-Lunga), Criuleni, Ialoveni, Stefan Voda, Taraclia and Falesti.
- Share of schools with unsatisfactory hygiene conditions is higher in the rural areas comparative to urban areas. Schools from rural areas lag behind both regarding the availability and satisfactory-technical conditions of the wash-basins, soap, single use towels, hand-dryers and water closets. For example, 19.2% of rural schools have wash-basins in poor condition (compared to 3.7% in urban area) and 29.2% lack soap (compared to 11.8 in urban areas). Nearly all rural schools (95%) have outside WCs on the cesspool. This means that about 55% of all students lack inside

126 Ibid., 2010: 14.
127 The health risk is assessed based on the proportion of students exposed to the risk factors.
WCs. Furthermore, in rural areas, only 22.7% of children have tap water at home, which represents an important obstacle for them in following hygiene practices.\textsuperscript{128}

### 3.5 Capacity and Policy Gaps

#### 3.5.1 Institutional Capacity

**Financing and medical insurance**

The reform of the health system has been marked by the introduction of the mandatory health insurance in 2004. The system is financed from the Mandatory Medical Insurance Fund, the state budget and internationally-funded programs dedicated to specific health problems. State Budget allocations to health has been increased in the last years, amounting to 6.5% GDP in 2009,\textsuperscript{129} which has been higher than those in the neighboring countries, Romania and Ukraine, but less than the EU-27 average.\textsuperscript{130}

Equity problems arise in what concerns coverage with health insurance.\textsuperscript{131} A study conducted by the National Bureau of Statistics in 2009 showed that 79.7% of population was covered with medical insurance, of which 51.3% was insured by the state, 26.7% by paying the monthly insurance and only 1.7% have bought their own medical insurance. The same study pointed out that as much as 30% of the population with the lowest income (first quintile) did not hold a medical insurance. The majority of population uncovered by the medical insurance was self-employed in agriculture (48.9%), while the others were employees (21.9%), unemployed (19.2%), or self-employed in non-agricultural activities (9.9%).

All children of the age group 0-18 years are covered with health insurance. Additionally, children under 5 years of age and pregnant women are provided medicines free of charge.


\textsuperscript{129} General government expenditures on health represented 4.9% of GDP in 2007, 5.4% in 2008 and 6.5% in 2009. IMF Country Report No. 10/232, July 2010: 11.

\textsuperscript{130} EU-27 average for health in total general government expenditure was of 7.4% of GDP in 2009. Data source: Eurostat, general government expenditure by function, date of accession: August 8, 2011.

Organizational structure and human resources

The administrative level responsible for primary and secondary care is the district level with the municipal one for Chisinau. The primary care is within the responsibility of family doctors. In rural areas, especially small localities are not covered with family doctors, but have access to family medical assistants. The secondary care is performed through hospitals located at district level. The Ministry of Health has in its direct subordination emergency services and specialized medical institutions, mostly located in Chisinau.

In order to improve the health state of the country population, the government has put an increasing emphasis on the development and enhancement of family medicine. A Primary Medical Assistance Development Strategy 2010-2013 was approved. The primary medical assistance was legally separated from the hospital and specialized ambulatory services. The separation procedure has started at the beginning of 2008. The number of Health Centers, which operate on the basis of contracts concluded directly with the National House of Medical Insurance, was raised to 54 compared to 32 in 2009. The rate of allocations from the Mandatory Medical Insurance Fund to primary medicine has been kept to 30%, in accordance with the legal provisions. 132

There has been a constant decline in absolute numbers of family doctors, from 2,136 in 2002 to 1,873 in 2010. Accordingly, the family doctors to inhabitants ratio has undergone a decrease from 5.8 in 2003 to 5.3 in 2010, which is much lower than the EU-27 average of 8.5 family doctors for every 10,000 inhabitants. The deficit of family doctors is highly accentuated in districts Cantemir (2.4), Hancesti (2.9), Leova (3) and Cimislia (3.1). The northern districts and the capital Chisinau are much better covered with family doctors. 133

The deficit of family doctors at the country level is estimated at 290 doctors. In one year, only 25 out of 60 family doctors new graduates choose to work in the rural area. Provided that this proportion will not increase, it takes up to 12 years to cover the deficit of physicians in the rural area.\textsuperscript{134}

Considering all doctors, not only the family ones, the gap between Moldova and the EU member states diminishes. However, Moldova remains at disadvantage with 29.8 doctors for every 10,000 inhabitants compared to over 32 the EU-27 average. Furthermore, statistics\textsuperscript{135} regarding specialized doctors reveal a worrying situation for the health of child and women. Merely one third of the total number of gynecologists trained during 2003-

\textsuperscript{134} Ibid.
\textsuperscript{135} Galbur (2010).
2009 work in the public health system, mostly in Chisinau. Just 30% of the trained pediatricians work in the health system. In seven districts, there is only one pediatrician working, one district has no pediatrician, and ten districts have no neonatologists.

On mental health, the study\textsuperscript{136} on \textit{Adolescent Health and Development} (2009) identifies several drawbacks on the provision of services. The first downside refers to the lack of psychologists and psychiatric staff in rural areas; only in 17 out of 35 districts there are child psychiatrists. Second is the lack of continuity with the primary health care system. The fragmentation of specialized care and the lack of coordination mechanisms between the psychological counseling system and the psychiatric system lead to deficiencies in data collection. Similar to other public health programs, the services developed at the community level have limited geographic coverage and strongly rely on international donor financing. Consequently, their sustainability is uncertain.

In Moldova, in 2010, over 61 thousands persons were employed in the sector of health and social assistance. Employment is highly concentrated in the public sector (97%) and feminized (80%). After a sharp decline, the number of employees in health and social assistance has increased since 2008.\textsuperscript{137} This increase was linked to the social protection reform and the corresponding rise of the number of social assistants (see section on Child Protection). The number of employees in the health sector has continued to decline.

The management of human resources in the health system is seriously affected by two negative aspects. First aspect is the mass migration of professionals. Over 9,000 doctors and nurses left the system between 1996 and 1999, and another 10,000 medical staff did the same in the period 2000-2008.\textsuperscript{138} An estimation of the phenomenon can be grasped through the number of certificates issued by the Ministry of Health for studies legalization, which are required for working abroad. Annually, Ministry of Health issues 200 certificates for doctors and 300 for medical staff with secondary schooling. The number can only be higher, especially for specialized staff with a secondary education degree, considering the informal jobs abroad. As result, for every 10,000 inhabitants, Moldova has less than 65 medical staff with secondary schooling as compared to 77.5 the EU-27 average.


\textsuperscript{137} National Bureau of Statistics, \url{http://statbank.statistica.md}. Data refers to the average monthly average of employees. Transnistria is not included.

Second aspect refers to the considerable disparities between urban and rural areas of the country, which have still remained important. Since 2006 the Government has made efforts for hiring of medical personnel in rural areas and districts, in particular young specialists. Thus, an increasing number of family doctors and medical assistants were distributed in the rural environment. In the first 8 months of 2010, 417 young specialists were hired (72 doctors and 345 medical assistants), and a total MDL 7.66 million were allotted for these specialists (MDL 30 thousand to each doctor and MDL 24 thousand to each medical assistant). In addition, for the improvement of the policy for medical personnel management, a human resource database in the field of health has been developed.

**Factors that hinder access to health services**

The lack of medical insurance impedes access to health services for about 20% of population.

The access of Roma to health services is problematic in Moldova as in other countries. In 2005-2006, only 23% of Roma households did have a medical insurance, which represented at that time about half of the

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proportion of general population.\(^{141}\) It is not clear whether the situation has improved or not in recent years as updated data is not available.

The lack of insurance is even stronger considering the poor knowledge of parents and adolescents on health issues, including information on the universality of health insurance for children and pregnant women. Thus, the low level of information of the population, particularly among vulnerable groups such as poor, numerous families or Roma, represents an additional factor which obstructs access to health care. For example, in 2009, 61.1% of households with three or more children did not go to the doctor because they believed that they did not have a medical insurance.\(^{142}\) A survey carried out in 2008 by the Ministry of Health revealed that approximately one third of respondents did not know the medical services included in the health insurance.\(^{143}\)

Underdeveloped transport infrastructure and transportation-related costs also represent factors, which hinder access to medical services, specifically because of the insufficient provision with health services in rural areas. The *Annual Report on Health* (2009)\(^{144}\) identifies 200 rural localities where a doctor comes only two or three times a week. In other 25 villages, there are no doctors at all. As result, 5.5% of households have limited access to health services due to location at long distances. The most disadvantaged groups include single parents with children, households with disabled persons and families with three or more children.\(^{145}\) Furthermore, for children with disabilities, early intervention services have been developed only in 4 districts (see figure 8). Alternatively, youth-friendly services are supplied only in 10 districts out of 35, and these do not outreach the most vulnerable or at risk adolescents.\(^{146}\)

Other factors that hamper access to health services come from practices of the population but also of the medical staff. For example, very few adolescents test for HIV, although voluntary counseling and testing services are available starting with 2008 in all districts, and HIV testing is free


\(^{146}\) UNICEF, Ministry of Health, *Mid-Term Review, UNICEF – Government of the Republic of Moldova Country Programme of Cooperation 2007-2011, Leadership Area, Adolescent Health and Development*, 2009: 31-32. In the Republic of Moldova, a total of 12 youth-friendly clinics are available, which are located in Chisinau, Balti and in 10 raions. In these clinics, multidisciplinary teams offer services. The offered services are OB/GYN consultations, STI counseling and management, urologist, psychologist or psychiatrist, social worker, internal medicine specialist services. Informational activities are oriented towards reproductive health, mental health, personal skills and communication, violence prevention, healthy lifestyle, prevention of HIV, TB and Hepatitis, healthy nutrition, and children rights.
of charge.\textsuperscript{147} The medical staff, on the other side, shows discriminatory attitudes and lack of confidentiality for children and families affected by HIV/AIDS. Another good example, the poor women as well as Roma women tend to address less the preventive health services due to their lower level of information, but also because of the prejudiced attitudes of the medical personnel (especially against Roma) and to the requested payments out of the pocket.\textsuperscript{148}

Out-of-pocket payments for health impede mostly poor households’ access to health services.\textsuperscript{149} They include direct payments for goods and services not covered by the health insurance, co-payment of goods and services included in the health insurance and informal payments to health personnel. Most of these expenditures go for payment of pharmaceuticals. In addition, a Transparency International study showed that health institutions ‘collect’ the highest number of informal payments from households. \textsuperscript{150}

Caregivers of persons with disabilities (including children) express the need for support, as the health insurance does not cover for the costs of many medicines and treatment. For going to the hospital, a family needs to rent a car which raises additional costs. Additionally, the cost of rehabilitation services is quite high. \textsuperscript{151}

Similar information regarding biased behaviors and attitudes of some doctors are reported by parents from poor families. For this reason, they tend to perceive the access to health services as unsatisfactory, particularly considering their consistent efforts to assure medical treatment when one of their children is sick. As coping strategy, they go to the doctor only in complicated cases, treating their children through traditional methods otherwise (in cases such as flues). \textsuperscript{152}

\subsection*{3.5.2 Policy Gaps and Solutions}

Universal access to quality public health, medical and pharmaceutical services, including achievement of the MDG targets represents Moldova’s
priorities in the health sector acknowledged within the Government’s Activity Program for 2011-2014. 153

Statistics and studies

An important problem related to monitoring access to health services is the quality of statistics. In this respect, the Republic of Moldova should make significant progress in supplying in a coherent and continuous manner the statistical indicators used at the international level in areas such as mental disorders. In the same time, detailed studies are needed in areas in which data are missing e.g. suicide, teenage mothers, etc.

For designing evidence-based policies and programs, statistics should also be available disaggregated by age, gender, ethnic group, social criteria and geographic distribution (including Transnistria).

Infant mortality

In order to ensure better policy effectiveness, in 2010, the Government of the Republic of Moldova issued a Rule on inter-sectoral social and medical collaboration mechanism in the field of prevention and decrease of the infant and under-five mortality at home and first 24 hours of hospitalization. 154 A pilot project for testing this mechanism was developed in four districts with the support of Lumos Foundation and UNICEF Moldova. This pilot project aims to develop and test the referral mechanism, expected to contribute to early identification of vulnerable families and to ensure referral to social and health services, ultimately contributing to prevention of infant and child mortality.

UNICEF also supports the Ministry of Health in the elaboration of a Parents and Adolescent Guide aimed to improve parent’s knowledge and practices for child care and development. 155 This initiative is highly relevant considering that in Moldova almost 20% of deaths of children under-five happen at home, the majority of cases from preventable causes of deaths. Nevertheless, its effectiveness remains to be seen, since parental education services are missing and the phenomenon may as well be linked to the large number of children left unsupervised by parents who left for work abroad.

**Maternal health**

Improved access to healthcare, especially in rural areas, adequate level of implementation of the protocols for monitoring and treating pregnant women as well as decreased poverty levels are considered the policy priorities in reducing maternal mortality.\(^ {156}\)

On the other hand, reducing the teen pregnancy is critical. Knowledge about safer sex behaviors should be seriously improved as unsafe sex behaviors continue to be dominant among young, especially among most-at-risk groups, which leads to teen unwanted pregnancies and high STI incidence. Access to free modern contraception needs to be extended also. In this respect, the youth-friendly services may be extended and enhanced regarding the outreaching activities or free condoms programmes.

**Malnutrition**

Latest analyses on the economic crisis impact recommend enhanced efforts for prevention of child malnutrition (continuing distribution of food to pregnant women, lactating mothers and children under 3 years old during winter time) and extended coverage of the *Early Childhood Development* program, focusing on young children (0 to 7 years of age) as the most vulnerable to malnutrition. This is of special importance in times of crisis, when the reduction in food consumption, in both quantity and quality, represents the dominant coping strategy for all households, including the poorer which concentrate the households with many children.\(^ {157}\)

**Children with disabilities**

Policy recommendations for children with disabilities focus on the development of early intervention services. Policy options\(^ {158}\) include development of such services at family doctors centres, development of an early intervention information system, training courses of professionals, and legislative improvements (on methodology and practices of working with the family of disabled child and review of Law on social integration of disabled people according to the European standards).

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Mental health and suicide

Evidence-based policy in this area is not possible as the current statistics do not provide accurate information on the incidence, distribution, structure and underlying causes of mental disorders in adolescents. The difference in classifications used by the European countries poses additional difficulties. Furthermore, the current monitoring system does not provide information to evaluate outcomes and key performance indicators for the mental health system.

The mental health services are insufficient, and the shortage is even more accentuated in providing care to children and adolescents. The system is fragmented and lacks multi-sectoral coordination between education and health systems both in terms of the data collection or referral system. Actually, the referral mechanism between the two sectors is not regulated, and in reality, does not exist. Furthermore, long-term community services to help family and community reintegration for children with mental or behavior disorders are scarce and heavily depend on external donor financing.

Adolescent health and development

The main achievements in this area include both developments of the legal and policy framework as well as improvement of services. The government has initiated and implemented Youth Law, Youth Strategy 2009-2013, a budgeted Plan of Action for 2009. Health policies are well-defined and have youth-specific activities, including national strategy and programs that address healthy lifestyles, HIV and Sexually Transmitted Infections, Reproductive Health, and Mental Health. The free health insurance covers children and youth up to 18 years. With support from international donors, 12 youth-friendly clinics were developed (since 2008 covered from the Health Insurance Fund). A national network of centers of voluntary counseling and testing has become available starting with year 2008 in each district (35 centers covered from the Health Insurance Fund). Several mechanisms of youth empowerment and participation have been developed in the whole country.

Several gaps remain, however, to be addressed. National policies and programs do not target most-at-risk adolescents or specific subpopulations in which the interventions may have the highest impact.159 Youth-friendly services have limited geographic coverage and do not have outreaching

programmes to most-at-risk adolescents, such as rural youth, youth from incomplete and poor families or without parental supervision, youth practicing high-risk behaviors, etc. A coherent and nation-wide educational policy for compulsory health education curricula contributing to increased knowledge on HIV/AIDS but also on effective life skills is still missing.\textsuperscript{160} Health prevention services and activities are underdeveloped and severely under-funded. In the same time, they are not integrated with the treatment services. Finally, budget allocations do not cover all activities included in the national strategies or programmes, and usually cover human resources and infrastructure maintenance with little left for the implementation of activities.

**HIV/AIDS**

In response to the growing challenge posed by the HIV/AIDS epidemic, a new Governmental Plan has been adopted in 2010 for the period left for achieving the MDG targets, *National Programme on Prevention and Control of HIV/AIDS and STI 2011–2015*. The following fields are considered as priority interventions:\textsuperscript{161}

- development and extension of prevention activities for the general population, including the rural one, migrants and other high-risk groups;
- continuous development of services for counseling and voluntary testing;
- development of infrastructure for improved universal access to medical assistance and palliative care through decentralization of antiretroviral treatment.

**Substance use**

There is no official estimation of the number of injecting drug users in the Republic of Moldova, which makes difficult a realistic policy design.


An extensive network of harm reduction (HR) services\textsuperscript{162} is available across the country. The volume of services they provide has continuously decreased due to shrinking financing after 2007. The financial sustainability of HR services should be considered on the longer term, as it is financed by the Government with 20%, while the rest is supported by international donors.\textsuperscript{163}

The existing HR program lacks ‘breaking-the-cycle’ interventions. For becoming more effective it needs to find solutions for extending the range of available services and coverage of younger cohorts. Otherwise, specifically in the absence of a comprehensive national school-based drug prevention program and considering the dominant practices of adolescents injecting drug users (indirect needles sharing and unsafe sex practices, even among the beneficiaries of harm reduction services), new generations will continue to feed on the system. This will lead to a persistent large number of children injecting drug users and most likely to higher HIV/STI transmission rates in the future.

The Framework Convention on Tobacco has been approved, but implementation lags behind. Possible effective measures include a significant increase in cigarette price, introduction of a smoking-cessation program for young, and education programs for preventing tobacco use.

Regarding alcohol, there is no national program of prevention and consumption reduction targeted to the youth. This is a major gap considering the high and increasing proportions of adolescents who drink alcohol, both among boys and girls, as well as the tolerant attitudes towards alcohol use.

**Access to water and sanitation**

Improvements in access to safe water sources and sanitation facilities need substantial investments, which require a large funding from both State Budget and external donors.

\textsuperscript{162} Implementation of the Harm Reduction Strategy (started in 1997) has been supported mainly by the Soros Foundation Moldova, also with the support of other international donors. Harm Reduction programmes are available starting with 2000, with a geographic expansion in 2003. At the end of 2007, needle exchange services were offered in 21 administrative territories (with extensions to rural areas) and in 6 penitentiary institutions. UNICEF, Ministry of Health, *Mid-Term Review, UNICEF – Government of the Republic of Moldova Country Programme of Cooperation 2007-2011, Leadership Area, Adolescent Health and Development*, 2009: 24-25.

3.6 Recommendations

- **To improve statistics** by adopting the international standard methodologies and by conducting detailed studies in the areas in which data are missing (e.g. mental health, suicide, injecting drug users, teenage mothers, etc.). For evidence-based programming, the national statistics should also be available disaggregated by age, gender, ethnic group, social criteria and geographic distribution (including Transnistria).

- **To develop legal mechanisms for public sector to contract NGOs** to provide youth-friendly services.

- **To improve the legislation** on methodology and practices of working with the family of disabled child and review of Law on social integration of disabled people according to the European standards.

- **To provide financing from the National Insurance Fund and implementing mechanisms** (also through contracting out services to NGOs), especially for preventive and health promotion activities.

- **To develop at community level the early identification of vulnerable families and to ensure referral to social and health services**, ultimately contributing to prevention of infant and child mortality.

- **To develop a national referral mechanism between the education and health systems** both in terms of the data collection and referral system for children and adolescents with mental and behavior disorders.

- **To introduce parental education services**, particularly for parents of children aged 0-3 years.

- **To continue the distribution of food** to pregnant women, lactating mothers and children under 3 years old during winter time and to extend coverage of the *Early Childhood Development* program, focusing on young children (0 to 7 years of age), for preventing child malnutrition during the period of crisis.
To expand geographic access to youth-friendly services, especially in rural areas, and for most vulnerable ones (including Transnistria region).

To increase the capacity of youth-friendly services to outreach the most vulnerable and to expand the range of preventive services such as free condoms programmes.

To develop the specialized services addressing the most-at-risk groups of young people (e.g. harm reduction programme including ‘break-the-circle’ interventions, drug and alcohol long-term rehabilitation services, smoking-cessation programme, etc.).

To introduce a coherent and nation-wide educational policy for compulsory health education curricula contributing to increased knowledge on HIV/AIDS but also on effective life skills.

To train professionals in contact with children and young (medical staff, social workers, particularly in rural areas).

To develop transport infrastructure for improved geographical access to medical assistance.

To improve access to safe water sources, sewerage and sanitation in the schools from rural areas.

To work with media to promote healthy lifestyle and to reduce the discriminatory attitudes towards vulnerable groups of children (e.g. Roma, people living with HIV, etc.).
Situation Analysis of Vulnerable, excluded and discriminated children in Moldova